Vaccine Administration Consent Form

Erickson Pharmacy

Section A (Please print clearly.)

First name: Last name:

Age: Date of birth: Gender (check one): ☐ Female ☐ Male ☐ Non-binary

Race: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander Ethnicity: ☐ Hispanic ☐ non-Hispanic

Home address:

City: State: ZIP Code:

Email address: Phone number:

Primary care physician name: Physician phone: Physician fax:

Please check the vaccinations you wish to receive today.

☐ Seasonal Influenza
☐ COVID-19
☐ Hepatitis A
☐ Hepatitis B
☐ Chickenpox (varicella)
☐ HPV
☐ Pneumococcal
☐ Tetanus/TDap
☐ Shingles (zoster)
☐ Meningococcal
☐ MMR
☐ Other
☐ RSV

Section B (The following questions will help us determine your eligibility for vaccination today.)

General Vaccine Screening Questions	Yes	No
1. Do you feel sick today?	☐	☐
2. Do you have any health conditions such as heart disease, diabetes or asthma? If yes, please list:	☐	☐
3. Do you have allergies to latex, medications, food or vaccines (e.g., eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? If yes, please list:	☐	☐
4. Have you ever had a reaction (allergic or otherwise) after receiving an immunization, including fainting or feeling dizzy?	☐	☐
5. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré Syndrome (a condition that causes paralysis) or other nervous system problem?	☐	☐
6. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS or transplant)?	☐	☐
7. For women: Are you pregnant or considering becoming pregnant in the next month?	☐	☐
Live vaccines	**Yes**	**No**
8. Have you received any vaccinations or skin tests in the past four weeks? If yes, please list:	☐	☐
9. Are you currently on home infusions, weekly injections such as Humira™ (adalimumab), Remicade™ (infliximab) or Enbrel™ (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?	☐	☐
10. Are you currently taking high-dose steroid therapy (prednisone > 20 mg/day or equivalent) for longer than two weeks?	☐	☐

11. Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year?	☐	☐
12. Are you currently taking any antibiotics, antiviral or antimalarial medications? (Typhoid only)	☐	☐
13. Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)	☐	☐
14. Are you receiving aspirin therapy or aspirin-containing therapy? (18 years of age and younger only)	☐	☐
15. Do you have a nasal condition serious enough to make breathing difficult (e.g., very stuffy nose)?	☐	☐

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Section C

COVID-19 Vaccine Screening Questions	Yes	No
16. Have you ever received a dose of COVID-19 vaccine? If yes, date of last dose: _____	☐	☐

17. Have you ever had an allergic reaction to a component of a COVID-19 vaccine, including either of the following:

- Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for ☐ ☐ colonoscopy procedures
- Polysorbate, which is found in some vaccines, film-coated tablets and intravenous steroids ☐ ☐

  - A previous dose of COVID-19 vaccine

  (This includes a severe allergic reaction, such as anaphylaxis, that required treatment with epinephrine or EpiPen™, or that caused you to go to the hospital. It also includes an allergic reaction that caused hives, swelling or respiratory distress, including wheezing.)

18. Check all that apply to you:

- ⑤ Have a history of myocarditis or pericarditis
- ⑤ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ⑤ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ⑤ Diagnosed with multisystem inflammatory syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ⑤ Have a weakened immune system (e.g., HIV, cancer) or take immunosuppressive drugs or therapies
- ⑤ Have a bleeding disorder
- ⑤ Take a blood thinner
- ⑤ Have a history of heparin-induced thrombocytopenia (HIT)
- ⑤ Am currently pregnant or breastfeeding
- ⑤ Have received dermal fillers
- ⑤ History of Guillain-Barré Syndrome (GBS)

Section D (Consent and Release)

I understand the benefits and risks of the vaccination(s) as described in the Vaccine Information Statement (VIS), a copy of which was provided with this Consent and Release. I request the vaccine(s) be given to me or to the person named below, a minor for whom I represent that I am authorized to sign this Consent and Release.

Signature of person to receive vaccine and VIS: Date:

(or parent/guardian, if recipient is younger than 18 years)

Insurance information and authorization:

☐ I hereby authorize the pharmacy to bill my insurance on my behalf for the immunizations and receive payment.

Non-medicare	Pharmacy	Medical	Medicare Card No. (Red, White and Blue Card)
Insurance plan name			
Member/recipient ID			
RX Bin		NA	

RX PCN	NA
Group No.	

Vaccine	MFR	Date admin.	Vaccine lot No.	Exp. date	Dosage	Injection site	VIS/EUA date	Dose in series
COVID-19								
Influenza								
Other								

Immunizer name (print): **Immunizer signature:**